

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 3 — 0 0 7

2. STATE:

Arkansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

September 1, 2003

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 440.20

7. FEDERAL BUDGET IMPACT:

a. FFY 2003 \$ -0-  
b. FFY 2004 \$ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, Page 1b  
Attachment 3.1-A, Page 1c  
Attachment 3.1-B, Page 2b  
Attachment 3.1-B, Page 2c9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):Same, Approved 01-~~13~~-97, TN 97-01  
Same, Approved 12-14-92, TN 91-59  
Same, Approved 01-~~13~~-97, TN 97-01  
Same, Approved 12-~~14~~-92, TN 91-59  
\*27

10. SUBJECT OF AMENDMENT:

The Arkansas Title XIX State Plan has been amended to reflect that prior authorization will no longer be required for outpatient emergency room services. A retrospective review will be performed by the PRO on a sampling of paid claims.

11. GOVERNOR'S REVIEW (Check One):

- ☒
- GOVERNOR'S OFFICE REPORTED NO COMMENT
- 
- ☐
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- 
- ☐
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:  
Roy Jeffus

14. TITLE:

Interim Director, Division of Medical Services

15. DATE SUBMITTED:  
June 27, 2003

16. RETURN TO:

Division of Medical Services  
P. O. Box 1437  
Little Rock, AR 72203-1437Attention: Binnie Alberius  
Slot S295

## FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

1 JULY 2003

18. DATE APPROVED:

8 AUGUST 2003

## PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

1 SEPTEMBER 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

ANDREW A. FREDRICKSON

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR  
DIV OF MEDICAID AND CHILDREN'S HEALTH

23. REMARKS:

\* Few ink change per states request.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-A  
Page 1b

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: August 1, 2003

CATEGORICALLY NEEDY

2.a. Outpatient Hospital Services

- (1) For the purpose of determining amount, duration and scope, outpatient hospital services are divided into four types of services:

- Emergency services
- Outpatient surgical procedures
- Non-emergency services
- Therapy/treatment services

Emergency Services

The determination of an emergency medical condition will be in compliance with Section 1867 of the Social Security Act.

A retrospective review will be performed by the Professional Review Organization (PRO) on a sampling of paid claims.

Non-emergency services may be necessary in the outpatient hospital setting when qualified physicians are not available in their offices or walk-in clinics to carry out the necessary treatment.

SUPERSEDES TN- 97-01

STATE	Arkansas
DATE REC'D	1 Jul 2003
DATE APPLIC	8 Aug 2003
DATE EFF	1 Sep 2003
HCFA 179	AR 03-07

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-A  
Page 1c

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

CATEGORICALLY NEEDY

Revised: August 1, 2003

2.a. Outpatient Hospital Services (Continued)

Outpatient Surgical Procedures

Coverage of outpatient surgical procedures are limited to procedures which the Arkansas Medicaid Program has determined to be safe and effective when performed on an outpatient basis.

Since outpatient surgical procedures are limited to approved services, no additional benefit limitations are imposed.

Treatment/Therapy Services

The covered outpatient hospital treatment/therapy services include, but are not limited to the following:

- Dialysis
- Radiation therapy
- Chemotherapy administration
- Physical therapy
- Occupational therapy
- Speech therapy
- Respiratory therapy
- Factor 8 injections
- Burn therapy

Treatment/therapy services, are included in the outpatient hospital services limit of twelve (12) visits per State Fiscal Year.

SUPERSEDES IN 91-59

STATE	Arkansas
DATE REC'D	1 Jul 2003
DATE APP'D	8 Aug 2003
DATE EFF	1 Sep 2003
MOSEA 179	AR 03-07

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-B  
Page 2b

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: August 1, 2003

**MEDICALLY NEEDED**

2.a. Outpatient Hospital Services

- (1) For the purpose of determining amount, duration and scope, outpatient hospital services are divided into four types of services:
- Emergency services
  - Outpatient surgical procedures
  - Non-emergency services
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SUPERSEDES 97-01

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-B  
Page 2c

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: August 1, 2003

CATEGORICALLY NEEDY

2.a. Outpatient Hospital Services (Continued)

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